FOR OHF USE

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0043406

Facility Name: WOODSIDE EXTENDED CARE

Address: 120 WEST 26TH ST (Number) SO.CHICAGO HTS. (City) 60411 (Zip Code)

County: COOK

Telephone Number: (847) 674-5795 **Fax #** (847) 674-5794

IDPA ID Number: 39-4153529

Date of Initial License for Current Owners: 11/01/97

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[X]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) MORRIS ESFORMES

(Title) MANAGER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)

(Print Name and Title) BOB KAGDA/PARTNER

(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD
3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124

(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Print Preview

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	64	Skilled (SNF)	64	23,424	1
2		Skilled Pediatric (SNF/PED)			2
3	48	Intermediate (ICF)	48	17,568	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	112	TOTALS	112	40,992	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	847		1,696	2,543	8
9	SNF/PED					9
10	ICF	37,007	82		37,089	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,854	82	1,696	39,632	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.68%

D. How many bed-hold days during this year were paid by Public Aid?
1,015 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/01/97

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/97 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 10 and days of care provided 1696

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	117,996	10,263	12,480	140,739		140,739	0	140,739			1
2	Food Purchase		130,554		130,554		130,554	(319)	130,235			2
3	Housekeeping	98,798	14,179	0	112,977		112,977	0	112,977			3
4	Laundry	37,497	13,984	6,407	57,888		57,888	0	57,888			4
5	Heat and Other Utilities			65,062	65,062		65,062	54	65,116			5
6	Maintenance	20,666	20,573	20,325	61,564		61,564	3,746	65,310			6
7	Other (specify):*			6,757	6,757		6,757	0	6,757			7
8	**TOTAL General Services**	274,957	189,553	111,031	575,541		575,541	3,481	579,022			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000	0	9,000			9
10	Nursing and Medical Records	963,819	63,601	9,433	1,036,853		1,036,853	890	1,037,743			10
10a	Therapy	23,677		306	23,983		23,983	0	23,983			10a
11	Activities	87,770	3,652	4,800	96,222		96,222	0	96,222			11
12	Social Services	0		2,425	2,425		2,425	0	2,425			12
13	Nurse Aide Training			0				0				13
14	Program Transportation			2,020	2,020		2,020	0	2,020			14
15	Other (specify):*							0				15
16	**TOTAL Health Care and Programs**	1,075,266	67,253	27,984	1,170,503		1,170,503	890	1,171,393			16
	C. General Administration											
17	Administrative	95,941		292,500	388,441		388,441	(210,618)	177,823			17
18	Directors Fees			0				0				18
19	Professional Services			33,760	33,760		33,760	11,422	45,182			19
20	Dues, Fees, Subscriptions & Promotions			15,088	15,088		15,088	(169)	14,919			20
21	Clerical & General Office Expenses	83,208	16,248	62,829	162,285		162,285	(37,155)	125,130			21
22	Employee Benefits & Payroll Taxes			227,218	227,218		227,218	0	227,218			22
23	Inservice Training & Education			2,150	2,150		2,150	58	2,208			23
24	Travel and Seminar			1,228	1,228		1,228	(1,228)				24
25	Other Admin. Staff Transportation			4,055	4,055		4,055	457	4,512			25
26	Insurance-Prop.Liab.Malpractice			51,188	51,188		51,188	1,072	52,260			26
27	Other (specify):*			0				6,724	6,724			27
28	**TOTAL General Administration**	179,149	16,248	690,016	885,413		885,413	(229,437)	655,976			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,529,372	273,054	829,031	2,631,457		2,631,457	(225,066)	2,406,391			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			23,763	23,763		23,763	(9,291)	14,472			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			15,050	15,050		15,050	1,011	16,061			32
33	Real Estate Taxes			237,764	237,764		237,764	1,025	238,789			33
34	Rent-Facility & Grounds			543,365	543,365		543,365	0	543,365			34
35	Rent-Equipment & Vehicles			26,388	26,388		26,388	3,768	30,156			35
36	Other (specify):* OFFICE RENT			6,451	6,451		6,451	(6,451)				36
37	TOTAL Ownership			852,781	852,781		852,781	(9,938)	842,843			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		27,603	32,782	60,385		60,385	0	60,385			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			61,488	61,488		61,488	0	61,488			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		27,603	94,270	121,873		121,873		121,873			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,529,372	300,657	1,776,082	3,606,111	0	3,606,111	(235,004)	3,371,107			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(10,452)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(319)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,228)	24		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(339)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(41)	20		28
29	Other-Attach Schedule DEFERRED MAINTENANCE	1,745	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (10,634)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(224,370)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (224,370)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (235,004)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Print Preview

Detail lines 29 and 35 of Page 5 starting in B44. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

STATE OF ILLINOIS **Page 5A**

Facility Name **WOODSIDE EXTENDED CARE**

ID# **0043406**

Report Period Beginning: **01/01/2000**

Ending: **12/31/2000**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
The information listed in B13 thru G43 is from Page 5.					
1	**Day Care**	0	0	**Line 1**	0
2	**Other Care for Outpatients**	0	0	**Line 2**	(319)
3	**Governmental Sponsored Special Programs**	0	0	**Line 3**	0
4	**Non-Patient Meals**	0	0	**Line 4**	0
5	**Telephone, TV & Radio in Resident Rooms**	0	0	**Line 5**	0
6	**Rented Facility Space**	0	0	**Line 6**	1,745
7	**Sale of Supplies to Non-Patients**	0	0	**Line 7**	0
8	**Laundry for Non-Patients**	0	0	**Line 8**	1,426
9	**Non-Straightline Depreciation**	(10,452)	30	**Line 9**	0
10	**Interest and Other Investment Income**	0	0	**Line 10**	0
11	**Discounts, Allowances, Rebates & Refunds**	0	0	**Line 10a**	0
12	**Non-Working Officer's or Owner's Salary**	0	0	**Line 11**	0
13	**Sales Tax**	(319)	2	**Line 12**	0
14	**Non-Care Related Interest**	0	0	**Line 13**	0
15	**Non-Care Related Owner's Transactions**	0	0	**Line 14**	0
16	**Personal Expenses (Including Transportation)**	0	0	**Line 15**	0
17	**Non-Care Related Fees**	(1,228)	24	**Line 16**	0
18	**Fines and Penalties**	0	0	**Line 17**	0
19	**Entertainment**	0	0	**Line 18**	0
20	**Contributions**	(339)	20	**Line 19**	0
21	**Owner or Key-Man Insurance**	0	0	**Line 20**	(380)
22	**Special Legal Fees & Legal Retainers**	0	19	**Line 21**	0
23	**Malpractice Insurance for Individuals**	0	0	**Line 22**	0
24	**Bad Debt**	0	0	**Line 23**	0
25	**Fund Raising, Advertising and Promotional**	0	0	**Line 24**	(1,228)
26	**Income & IL Personal Property ReplacementTaxes**	0	0	**Line 25**	0
27	**Nurse Aide Training for Non-Employees**	0	0	**Line 26**	0
28	**Yellow Page Advertising**	(41)	20	**Line 27**	0
29	**Non-Paid Workers**	0	0	**Line 28**	(1,608)
30	**Donated Goods**	0	0	**Line 29**	(182)
31	**Amortization Expense**	0	0	**Line 30**	(10,452)
32	PG 5 LINE 29 - DEFERRED MAINTENANCE XIX-H	1,745	6	**Line 31**	0
33				**Line 32**	0
34				**Line 33**	0

Print Other Adjustments

Line 34	0
Line 35	0
Line 36	0
Line 37	(10,452)
Line 38	0
Line 39	0
Line 40	0
Line 41	0
Line 42	0
Line 43	0
Line 44	0
Line 45	(10,634)

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number WOODSIDE EXTENDED CARE **#** 0043406 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(319)	0	0	0	0	0	0	0	0	0	0	(319)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	54	0	0	0	0	0	0	0	0	54	5
6	Maintenance	1,745	1,492	509	0	0	0	0	0	0	0	0	3,746	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	1,426	1,492	563	0	0	0	0	0	0	0	0	3,481	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	890	0	0	0	0	0	0	0	0	0	890	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	890	0	0	0	0	0	0	0	0	0	890	16
	C. General Administration													
17	Administrative	0	0	(210,618)	0	0	0	0	0	0	0	0	(210,618)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	10,983	439	0	0	0	0	0	0	0	0	11,422	19
20	Fees, Subscriptions & Promotions	(380)	211	0	0	0	0	0	0	0	0	0	(169)	20
21	Clerical & General Office Expenses	0	(42,643)	5,488	0	0	0	0	0	0	0	0	(37,155)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	58	0	0	0	0	0	0	0	0	0	58	23
24	Travel and Seminar	(1,228)	0	0	0	0	0	0	0	0	0	0	(1,228)	24
25	Other Admin. Staff Transportation	0	148	309	0	0	0	0	0	0	0	0	457	25
26	Insurance-Prop.Liab.Malpractice	0	737	335	0	0	0	0	0	0	0	0	1,072	26
27	Other (specify):*	0	4,534	2,190	0	0	0	0	0	0	0	0	6,724	27
28	**TOTAL General Administration**	(1,608)	(25,972)	(201,857)	0	0	0	0	0	0	0	0	(229,437)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(182)	(23,590)	(201,294)	0	0	0	0	0	0	0	0	(225,066)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number WOODSIDE EXTENDED CARE **#** 0043406 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(10,452)	437	724	0	0	0	0	0	0	0	0	(9,291)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	1,011	0	0	0	0	0	0	0	0	1,011	32
33	Real Estate Taxes	0	0	1,025	0	0	0	0	0	0	0	0	1,025	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	2,376	1,392	0	0	0	0	0	0	0	0	3,768	35
36	Other (specify):*	0	0	(6,451)	0	0	0	0	0	0	0	0	(6,451)	36
37	**TOTAL Ownership**	(10,452)	2,813	(2,299)	0	0	0	0	0	0	0	0	(9,938)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(10,634)	(20,777)	(203,593)	0	0	0	0	0	0	0	0	(235,004)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

Show Pgs 6A thru 6D | Show Pgs 6E thru 6I | Hide Pgs 6A thru 6I

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				EKS MGMT	LINCOLNWOOD	BOOKKEEPING
SEE ATTACHED SCHEDULES		SEE ATTACHED SCHEDULES		EMI ENTERPRISES	LINCOLNWOOD	MGMT CONSULT
				IME REALTY	LINCOLNWOOD	HOME OFFICE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6
1	V	21	OUTSIDE CLERICAL	$ 63,312	EKS MANAGEMENT		$	$ (63,312)	1	-63312
2	V	6	MAINTENANCE		" "		1,492	1,492	2	1492
3	V	10	NURSING		" "		890	890	3	890
4	V	19	PROFESSIONAL FEES		" "		10,983	10,983	4	10983
5	V	20	WANT ADS		" "		211	211	5	211
6	V	21	CLERICAL		" "		20,669	20,669	6	20669
7	V	23	SEMINARS		" "		58	58	7	58
8	V	25	STAFF TRANSPORTATION		" "		148	148	8	148
9	V	26	INSURANCE		" "		737	737	9	737
10	V	27	EMPLOYEE BENEFITS		" "		4,534	4,534	10	4534
11	V	30	SL DEPRECIATION		" "		437	437	11	437
12	V	35	EQUIPMENT RENT		" "		2,376	2,376	12	2376
13	V								13	
14	Total			$ 63,312			$ 42,535	$ * (20,777)	14	

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line 1 Line 2

Print Page 6A

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	17	MANAGEMENT FEES	$ 222,500	EMI ENTERPRISES		$	$ (222,500)	15	-222500
16	V	17	OFFICERS SALARY		" "		11,882	11,882	16	11882
17	V	19	ACCOUNTING FEES		" "		389	389	17	389
18	V	21	CLERICAL		" "		5,454	5,454	18	5454
19	V	25	STAFF TRANSPORTATION		" "		309	309	19	309
20	V	26	INSURANCE		" "		287	287	20	287
21	V	27	EMPLOYEE BENEFITS		" "		2,190	2,190	21	2190
22	V	30	SL DEPRECIATION		" "		191	191	22	191
23	V	35	AUTO LEASE		" "		1,392	1,392	23	1392
24	V								24	
25	V	36	OFFICE RENT	6,451	IME REALTY			(6,451)	25	-6451
26	V	5	UTILITIES		" "		54	54	26	54
27	V	6	REPAIRS/MAINTENANCE		" "		509	509	27	509
28	V	19	PROFESSIONAL FEES		" "		50	50	28	50
29	V	21	OFFICE EXPENSE		" "		34	34	29	34
30	V	26	INSURANCE		" "		48	48	30	48
31	V	30	SL DEPRECIATION		" "		533	533	31	533
32	V	32	INTEREST		" "		1,011	1,011	32	1011
33	V	33	REAL ESTATE TAX		" "		1,025	1,025	33	1025
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$ 228,951			$ 25,358	$ * (203,593)	39	

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Print Preview

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5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6B

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6B

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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Print Page 6C

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6C

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Print Preview

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2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
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Print Page 6D

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Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6D

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ALLOCATION FROM EMI ENTERPRISES:				SEE ATTACHED				$		1
2	MORRIS ESFORMES	PRESIDENT	MGMT CONSULT	40.00	SCHEDULE	5	7.25	SALARY	11,882	17-7	2
3											3
4											4
5	PHILIP ESFORMES	MGMT CONSULT	MGMT CONSULT	25.00		10		MGMT FEE	70,000	17-3	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 81,882		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Print Preview

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D | Show Pgs 8E thru 8I | Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EKS MANAGEMENT
Street Address: 3737 W ARTHUR
City / State / Zip Code: LINCOLNWOOD IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINTENANCE	CENSUS DAYS	617,052		$ 23,229	$ 23,229	39,632	$ 1,492	1
2	10	NURSING	" "	617,052		13,856	13,856	39,632	890	2
3	19	PROFESSIONAL FEES	" "	617,052		170,994		39,632	10,983	3
4	20	WANT ADS	" "	617,052		3,290		39,632	211	4
5	21	CLERICAL	" "	617,052		321,801	269,163	39,632	20,669	5
6	23	SEMINARS	" "	617,052		905		39,632	58	6
7	25	STAFF TRANSPORTATION	" "	617,052		2,302		39,632	148	7
8	26	INSURANCE	" "	617,052		11,476		39,632	737	8
9	27	EMPLOYEE BENEFITS	" "	617,052		70,589		39,632	4,534	9
10	30	SL DEPRECIATION	" "	617,052		6,797		39,632	437	10
11	35	EQUIPMENT RENT	" "	617,052		36,988		39,632	2,376	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 662,227	$ 306,248		$ 42,535	25

Print Preview

Print Page 8A

STATE OF ILLINOIS

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EMI ENTERPRISES
Street Address: 3737 W ARTHUR
City / State / Zip Code: LINCOLNWOOD IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICERS SALARY	CENSUS DAYS	617,052		$ 185,000	$ 185,000	39,632	$ 11,882	1
2	19	ACCOUNTING FEES	" "	617,052		6,053		39,632	389	2
3	21	CLERICAL	" "	617,052		84,917	64,123	39,632	5,454	3
4	25	STAFF TRANSPORTATION	" "	617,052		4,810		39,632	309	4
5	26	INSURANCE	" "	617,052		4,462		39,632	287	5
6	27	EMPLOYEE BENEFITS	" "	617,052		34,099		39,632	2,190	6
7	30	SL DEPRECIATION	" "	617,052		2,964		39,632	191	7
8	35	AUTO LEASE	" "	617,052		21,677		39,632	1,392	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 343,982	$ 249,123		$ 22,094	25

Print Preview

Print Page 8B

STATE OF ILLINOIS

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: IME REALTY
Street Address: 3737 W ARTHUR
City / State / Zip Code: LINCOLNWOOD IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	RENTAL INCOME	201,349		$ 1,685	$	6,451	$ 54	1
2	6	REPAIRS/MAINTENANCE	" "	201,349		15,902		6,451	509	2
3	19	PROFESSIONAL FEES	" "	201,349		1,575		6,451	50	3
4	21	OFFICE EXPENSE	" "	201,349		1,047		6,451	34	4
5	26	INSURANCE	" "	201,349		1,504		6,451	48	5
6	30	SL DEPRECIATION	" "	201,349		16,647		6,451	533	6
7	32	INTEREST	" "	201,349		31,549		6,451	1,011	7
8	33	REAL ESTATE TAX	" "	201,349		32,000		6,451	1,025	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 101,909	$		$ 3,264	25

Print Preview

Print Page 8C

STATE OF ILLINOIS

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8D

STATE OF ILLINOIS

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	RELATED PARTY: IME REALTY		X	MORTGAGE			$	$			$ 1,011	1
2												2
3												3
4												4
5												5
	Working Capital											
6	BRICKYARD BANK		X	WORKING CAPITAL	$1,578.00	11/98	150,000	133,328	10/2002	9.5	14,115	6
7	TRANSAMERICA		X	INSURANCE FINANCING							935	7
8												8
9	TOTAL Facility Related				$1,578.00		$ 150,000	$ 133,328			$ 16,061	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 150,000	$ 133,328			$ 16,061	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Print Preview

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	217,510	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	226,504	2
3. Under or (over) accrual (line 2 minus line 1).	$	8,994	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	228,770	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	237,764	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	197,808	8
	1996	137,696	9
	1997	200,823	10
	1998	215,360	11
	1999	226,504	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 1999 TAX YEAR.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**

This denial must be no more than four years old at the time the cost report is filed.

Print Preview

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,900 B. General Construction Type: Exterior CONCRETE Frame METAL/CONCRETE Number of Stories 1 + BASEMENT

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B | Show Pgs 12C and 12D | Hide Pgs 12A thru 12D

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	CEILING LIGHTING			1997	3,746	96	39	96		300	9
10	WATER SOFTENING SYSTEM			1997	6,926	178	39	178		556	10
11	FLOORING			1997	3,910	100	39	100		304	11
12	FLOORING / DOORS / WINDOWS			1998	29,194	748	39	748		1,970	12
13	ROOF			1998	84,450	2,165	39	2,165		6,228	13
14	DUMBWAITER/FAUCETS/CABINETS/WALLPAP./CUB.CURT.			1998	30,915	793	39	793		2,290	14
15	PAINTING / DECORATING			1998	15,111	387	39	387		984	15
16	FLOORING / DOORS / BATHROOM FIXTURES			1999	11,198	288	39	288		556	16
17	CHAIN LINK FENCE			1999	5,100	131	39	131		191	17
18	FLOOR TILES/COVE BASE			2000	22,766	793	27.5	793		793	18
19	PAIR OF ALUMINUM DOORS			2000	2,193	63	27.5	63		63	19
20	PLUMBING			2000	9,913	45	27.5	45		45	20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32	RELATED PARTY ALLOCATION - IME REALTY					437		437			32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 6,224		$ 6,224	$	$ 14,280	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
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31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12B

STATE OF ILLINOIS

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
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31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12C

STATE OF ILLINOIS

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
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31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12D

STATE OF ILLINOIS

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
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33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 92,187	$ 15,991	$ 6,941	$ (9,050)	8 - 15 YRS	$ 19,546	37
38	Current Year Purchases	13,888	1,985	583	(1,402)	10 - 15 YRS	583	38
39	Fully Depreciated Assets							39
40	RELATED PARTY ALLOC - EKS MGMT 437/EMI ENTERP 191/IME REALTY 96		724	724				40
41	TOTALS	$ 106,075	$ 18,700	$ 8,248	$ (10,452)		$ 20,129	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 24,924	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 14,472	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (10,452)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 34,409	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: MAJ ENTERPRISES INC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		112	11/98	$ 543,365	19		3
4	Additions							4
5								5
6								6
7	TOTAL		112		$ 543,365 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☒ X NO Terms: *

10. Effective dates of current rental agreement:
Beginning 11/01/1998
Ending 10/31/2017

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$ 553,583
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 15,667 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY USE	'98 FORD 350E WAGON	$ 650.00	$ 7,833	17
18	ADMIN,ETC	'97 ACURA RL	650.00	5,488	18
19					19
20		LESS PAYROLL DEDUCTION:		(2,600)	20
21	TOTAL		$ #######	$ 10,721	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Print Preview

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY TRAINED AIDES.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Preview

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 15,176	$		$ 15,176	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			417			417	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			17,189			17,189	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				17,169		17,169	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	RADIOLOGY / LABS / OTHER / Other (specify): & SUPPLIES	39-2					10,434		10,434	13
14	TOTAL			$		$ 32,782	$ 27,603		$ 60,385	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

Facility Name & ID Number WOODSIDE EXTENDED CARE **#** 0043406 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2000 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 121,159	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 100,000)	981,957		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	51,713		6
7	Other Prepaid Expenses	2,263		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): R.E. TAX ESCROW	193,254		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,350,346	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	225,423		15
16	Equipment, at Historical Cost	106,075		16
17	Accumulated Depreciation (book methods)	(68,930)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 262,568	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,612,914	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 118,401	$	26
27	Officer's Accounts Payable	254,351		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	133,328		29
30	Accrued Salaries Payable	51,796		30
31	Accrued Taxes Payable (excluding real estate taxes)	26,082		31
32	Accrued Real Estate Taxes(Sch.IX-B)	228,770		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 812,728	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 812,728	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 800,186	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,612,914	$	48

***(See instructions.)**

Print Preview

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 453,936	1	
2	Restatements (describe):		2	
3	IL REPLACEMENT TAX	(3,488)	3	
4	ROUNDING	6	4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 450,454	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	766,732	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(417,000)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 349,732	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 800,186	24	*

*** This must agree with page 17, line 47.**

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Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,363,557	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,363,557	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	9,286	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 9,286	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,372,843	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 575,541	31
32	Health Care	1,170,503	32
33	General Administration	885,413	33
	B. Capital Expense		
34	Ownership	852,781	34
	C. Ancillary Expense		
35	Special Cost Centers	60,385	35
36	Provider Participation Fee	61,488	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,606,111	40
41	**Income before Income Taxes (line 30 minus line 40)****	766,732	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 766,732	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Print Preview

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,254	$ 53,083	$ 23.55	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,310	3,553	64,469	18.14	3
4	Licensed Practical Nurses	19,063	21,317	361,653	16.97	4
5	Nurse Aides & Orderlies	56,372	61,058	456,099	7.47	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,897	2,160	23,677	10.96	8
9	Activity Director					9
10	Activity Assistants	10,614	11,716	87,770	7.49	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,236	17,393	117,996	6.78	15
16	Dishwashers					16
17	Maintenance Workers	2,150	2,297	20,666	9.00	17
18	Housekeepers	14,509	15,042	98,798	6.57	18
19	Laundry	5,631	6,096	37,497	6.15	19
20	Administrator	2,080	2,172	95,941	44.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,093	9,889	83,208	8.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) MDS COORD	1,907	1,907	28,515	14.95	33
34	TOTAL (lines 1 - 33)	144,942	156,854	$ 1,529,372 *	$ 9.75	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 11,360	1-3	35
36	Medical Director	O	9,000	9-3	36
37	Medical Records Consultant	N	1,100	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	2,712	10-3	39
40	Physical Therapy Consultant	L	306	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	4,800	11-3	44
45	Social Service Consultant	E	2,425	12-3	45
46	Other(specify)	S			46
47	PSYCHO-SOCIAL CONSULTANT		1,800	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 33,503		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

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Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LES OKUN	ADMIN	0.00%	$ 95,941
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 95,941

B. Administrative - Other

Description		Amount
EMI ENTERPRISES	MGMT FEES	$ 222,500
PHILIP ESFORMES	MGMT FEES	70,000
TOTAL (agree to Schedule V, line 17, col. 3)		$ 292,500
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
ALPHA DATA	DATA PROCESSING	$ 3,893
IIT/SOURCETECH	DATA PROCESSING	1,500
HDSI	DATA PROCESSING	2,237
MID AMERICA	DATA PROCESSING	1,320
NCS	DATA PROCESSING	4,260
MUTUAL OF OMAHA	DATA PROCESSING	250
KBKB	ACCOUNTING	11,100
PERSONNEL PLANNERS	UNEMPLOYMENT CONS.	475
KELLY	PROPERTY APPRAISALS	3,850
RICHARD PEELO	M/C COST REPORTING	4,875
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 33,760

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 43,331
Unemployment Compensation Insurance	38,823
FICA Taxes	115,791
Employee Health Insurance	27,403
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
PENSION/PROFIT SHARING CONTRIB	0
EMPLOYEE BENEFITS-OTHER	1,870
EMPLOYEE PHYSICAL EXAMS	0
INSURANCE EXECUTIVE LIFE	0
CHICAGO HEAD TAX	0
INSURANCE EXECUTIVE LIFE	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 227,218

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	8,209
Health Care Worker Background Check	274
(Indicate # of checks performed 23)	
ADV & PROMO/MARKETING	41
DUES & SUBSCRIPTIONS	4,481
LICENSES & PERMITS	1,744
TRUST FEES, CONTRIBUTIONS,etc.	339
MGMT CO ALLOCATION	211
LESS TRUST FEES, CONTRIB, etc.	(339)
Less: Public Relations Expense	( )
Non-allowable advertising	(0)
Yellow page advertising	(41)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,919

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

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Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	PAINT/DECORATINC	1998	$ 3,384	3	$	$ 564	$ 1,128	$ 1,128	$ 564	$	$	$	$
2	PAINT/DECORATINC	1999	1,851	3			309	617	617	308			
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 5,235		$	$ 564	$ 1,437	$ 1,745	$ 1,181	$ 308	$	$	$

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Facility Name & ID Number WOODSIDE EXTENDED CARE **#** 0043406 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE 4406**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **YES** If YES, have these costs
been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **438** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
of Public Aid during this cost report period. $ **61,488**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit
on Schedule V. $ **0** Has any meal income been offset against
related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all othe
times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjustec
out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service
performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

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Facility Name & ID Number WOODSIDE EXTENDED CARE #0043406 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF		TOTAL
1	DIETARY			
	DIETITIAN CONSULTANT	XVIII B35	11360	
	REPAIRS & MAINTENANCE		1120	
			0	12480
3	HOUSEKEEPING			
			0	
			0	0
4	LAUNDRY			
	EQUIPMENT REPAIRS & MAINTENANCE		6407	
			0	6407
5	HEAT & OTHER UTILITIES			
	GAS HEAT		13649	
	ELECTRICITY		42053	
	WATER		9360	
	CABLE TV - LOBBY		0	
			0	65062
6	MAINTENANCE			
	GROUNDS MAINTENANCE		2324	
	PAINTING & DECORATING		1401	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		4962	
	ELEVATOR MAINTENANCE & REPAIR		1320	
	OUTSIDE LABOR		826	
	EXTERMINATING SERVICE		2100	
	FIRE SERVICE		7392	
			0	
			0	
			0	20325
7	OTHER			
	SCAVENGER		6297	
	SECURITY SERVICE		460	6757
9	MEDICAL DIRECTOR			
	MEDICAL DIRECTOR FEES	XVIII B36	9000	9000

LINE		SCHED REF		TOTAL
10	NURSING			
	CONTRACT NURSING	XVIII C53	0	
	LABORATORY & XRAY EXPENSE		796	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B47	1800	
	RESTORATIVE NURSING CONSULTANT	XVIII B38	0	
	MEDICAL RECORDS CONSULTANT	XVIII B37	1100	
	PHARMACY CONSULTANT	XVIII B39	2712	
	UTILIZATION REVIEW FEES	XVIII B	0	
	PHYSICIANS	XVIII B	0	
	PSYCHIATRIC	XVIII B	0	
	RN CONSULTANT	XVIII B38	0	
	DENTAL SERVICES		3025	
			0	9433
10a	THERAPY			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B40	306	
	OCCUPATIONAL THERAPY CONSULTAN	XVIII B41	0	
	SPEECH THERAPY CONSULTANT	XVIII B43	0	
	RESPIRATORY CONSULTANT	XVIII B42	0	306
11	ACTIVITIES			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B44	4800	
			0	4800
12	SOCIAL SERVICES			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTANT	XVIII B45	2225	
	SOCIAL WORKER	XVIII B45	200	
			0	2425
13	NURSE AIDE TRAINING			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number WOODSIDE EXTENDED CARE #0043406 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF		TOTAL
14	PROGRAM TRANSPORTATION			
	PATIENT TRANSPORTATION		2020	2020
17	ADMINISTRATIVE			
	MANAGEMENT FEES	XIX B	292500	292500
18	DIRECTORS FEES		0	0
19	PROFESSIONAL SERVICES			
	DATA PROCESSING	XIX C	13460	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	20300	
	ACCOUNT COLLECTION FEES		0	33760
20	FEES,SUBSCRIPTIONS,PROMOTIONS			
	ENTERTAINMENT	VI 19 XIX F	0	
	ADV & PROMO/MARKETING	VI 25 XIX F	0	
	EMPLOYEE WANT ADS	XIX F	8209	
	CONTRIBUTIONS	VI 20 XIX F	125	
	DUES & SUBSCRIPTIONS	XIX F	4481	
	LICENSES & PERMITS	XIX F	1744	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	41	
	TRUST FEES/FRANCHISE TAX	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	214	
	H/CARE WORKER BACKGROUND CHECK	XIX F	274	15088
21	CLERICAL & GENERAL OFFICE EXPENSES			
	BANK CHARGES		15	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		45312	
	PENALTIES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		17502	
	MESSENGER SERVICE		0	
			0	62829

LINE		SCHED REF		TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES			
	FICA TAXES	XIX D	115791	
	UNEMPLOYMENT COMPENSATION	XIX D	38823	
	WORKERS COMPENSATION INSURANCE	XIX D	43331	
	HOSPITALIZATION INSURANCE	XIX D	27403	
	EMPLOYEE BENEFITS - OTHER	XIX D	1870	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING CONTRIB	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	227218
23	INSERVICE TRAINING & EDUCATION			
	EDUCATION & SEMINARS		2150	2150
24	TRAVEL & SEMINARS			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	1228	
			0	
				1228
25	ADMIN. STAFF TRANSPORTATION			
	TRANSPORTATION - STAFF		4055	4055
26	INSURANCE - PROP. LIAB & MALPRACTICE			
	GENERAL INSURANCE		51188	51188
27	OTHER			
	BAD DEBTS	VI 24	0	
			0	0
	GRAND TOTAL COLUMN 3 OTHER			829031